

patients endure, but there is no substitute for personal experience. We should not hesitate to bring our personal experiences to use, being mindful, of course, of not overstepping boundaries.

—Joel Weinstein MD CCFP FCFP
North York, Ont

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Empathy training a must for physicians

Kudos to *Canadian Family Physician* for bringing the issue of empathy to the foreground,^{1,2} and to Lussier and Richard for emphasizing the need to distinguish between empathy and sympathy.¹

I discuss the importance of empathy when teaching physicians about that most invisible of conditions: chronic noncancer pain. I show learners a photograph of a trauma patient in the emergency department and ask them how they feel. I share that I feel overwhelmed, horrified, and helpless, while emergency and advanced trauma life support-trained colleagues have said that they feel “pumped” because they know how to help this victim. I point out that technical skills help physicians to maintain their boundaries and to remain effective in uncomfortable situations.

Then I discuss chronic noncancer pain, which is underrepresented in most medical school curricula, leaving physicians with minimal knowledge on the approach to diagnosis and treatment. I discuss the fact that functional magnetic resonance imaging studies have shown that observing someone in pain “activates similar neurons as if the observer were feeling pain himself.”³ Authors of these studies go on to state that “[it is important to] differentiate the observer’s sense of knowing the other’s personal experience and his/her personal affective response to this [experience]. When unsuccessful in differentiating, the observer may get overwhelmed by distress [leading to] further distress and helplessness in both.”³

Studies have shown that empathy declines in medical students as they proceed with their training, yet empathy is a crucial element in the therapeutic encounter and the linchpin of narrative medicine.^{4,5} Training is required for both technical skills and emotional balance. Without this, physicians remain at risk of becoming overwhelmed and helpless in the face of suffering—or, even worse, cold, detached, and disbelieving.

—Ruth Dubin MD PhD FCFP
Kingston, Ont

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Rebuttal: palivizumab for the prevention of respiratory syncytial virus infection

In the article on palivizumab for the prevention of respiratory syncytial virus infection,¹ Rogovik et al summarized current literature on palivizumab safety, efficacy, use, and cost-effectiveness. The primary objectives were to determine the indications for the use of palivizumab and whether it can be used in the treatment of respiratory syncytial virus (RSV) infections.

Although the recommendations for palivizumab use from the Canadian Paediatric Society² are summarized, the discussion largely focuses on recommendations by the American Academy of Pediatrics,³ which is disappointing given the substantial research contributions to this field by the Pediatric Investigators Collaborative Network on Infections in Canada (PICNIC) and other Canadian investigators. As mentioned in the Canadian guidelines, there are important differences between the 2 position statements owing to unique epidemiology, geography, and practice settings, in addition to different health care systems and drug costs. Recommendations for infants at a gestational age (GA) of 32 to 35 weeks are the most divergent, with Canadian guidelines recommending localized policies in each province and territory, considering risk factors and the available risk-scoring

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